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THE ROLE OF HEALTH SERVICES IN SUPPORT OF THE THEATER CAMPAIGN PLAN

BY

LIEUTENANT COLONEL IAN L. NATKIN

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THE ROLE OF HEALTH SERVICES IN SUPPORT OF THE
THEATER CAMPAIGN PLAN

AN INDIVIDUAL STUDY PROJECT

by

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Carlisle Barracks, Pennsylvania 17013
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ABSTRACT

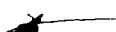
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THE ROLE OF HEALTH SERVICES
IN SUPPORT OF THE
THEATER CAMPAIGN PLAN

CHAPTER I

INTRODUCTION

Campaign planning- the codifying of the operational art of war- is often portrayed as an enigma waiting to be rediscovered. Why rediscovered? Campaigns have been conducted since the earliest of times, and always have had some degree of success for at least one of the armies participating in the campaign. This success was the result of a plan, possibly an oral informal plan easily understood, or a complex written plan requiring hours of study prior to execution.

As enigmatic as campaign planning in general may be, timely sustainment planning in particular needed for the preparation of the campaign plan remains a cipher. Granted, we have manuals listing specific planning factors and utilization rates, but the specific contributory factors of the logistics support plan are rarely, if ever, integrated into initial plans. The Army of the future, more so than any force in history, will require personnel capable of operating independently and smartly with limited

assets and little direction. It is thus important to understand the impact and interdependence of logistical factors on the campaign plan.

One important area of logistics often relegated to numerical, as opposed to subjective, support structure formulation is that of health service support. While this support can be provided using pure allocation rules, the impact and contribution of timely health service support can also affect the outcome of a campaign. Unfortunately, when a campaign plan is first published, many supporting annexes, to include medical, are often either omitted or given the common explanatory notation "to be published". I will show the early implementation of medical supporting plans may avert the combat portion of campaign execution. To do this, I will describe the overall impact of medical planning, highlighting utilization of assets in the initial low intensity phase of the campaign. A discussion of doctrine and significant medical campaign areas will be compared to progress made in the European theater to correct serious medical deficiencies.

CHAPTER II

MEDICAL POWER

Power. This word conjures up many meanings based on the interests and perspective of the reader. The mention of the word "medical" does not have the same effect; its meaning is usually the same to personnel in developed nations. By combining the two words, you get a phrase that at first glance appears to be a mistake-medical power. I will discuss the application of this phrase as it applies to the attainment of national policy.

The Army War College's definition of national power includes four elements- political, economic, sociopsychological and military.¹ The application of these elements, to be successful, should be used in an integrated fashion to further national interests. The military element of power can be further separated into violent and nonviolent means. When military power must be used in a violent way, the greater part of the national objective- peace-has not been accomplished. Clausewitz states the ultimate end war seeks to accomplish, following successful

attainment of the political objective, is peace.² If one of the stated ends of national strategy is also peace, it is obviously safer, less costly and less traumatic to use nonviolent means if the same end can be achieved. The application of violence may be a tacit admission that a reactive, versus planned, strategy has had to be effected. Rather than act in a reactive mode, judicious application of nonviolent military means could assist in attaining the same end.

Nonviolent military means can mean the provision of training, equipment, personnel or other programs utilizing military resources. A simplistic view of this has often consisted of moving massive amounts of combat forces and equipment, with the requisite support structure, into an area. The period between the arrival of forces and the initiation of hostilities was considered the period of application of nonviolent military means. The support forces, to include medical, were utilized solely to augment combat power. Nations are rediscovering that rather than augmenting combat power, the support forces can be utilized as a separate element of power projection in themselves.

Recently, the United States focus in national strategy has, by necessity, begun to shift to third world nations. Many of the third world nations are considered developing, or emerging, societies. It is in these areas that the utilization of nonviolent military power has the potential to have the greatest success. Earlier, I mentioned the importance of having a planned rather than reactive strategy. The third world offers the

opportunity to assist in nation building in a planned, proactive way, while allowing a developmental base for reactive escalation if needed.

Discussion of nonviolent means commonly refers to such areas as engineer and medical support. Concentrating on medical support, the United States has an opportunity to assist not only developing nations, but also assist the United States. One clarification is needed to dispel a common belief: medical support is not just going out into a rural area and setting up Viet Nam style medical civic action programs (MEDCAPS), although I will show the importance of this aspect later in the paper. MEDCAPS are effective; however, they must be used as part of a larger program. Medical support must include a program of identification of health problems affecting the nation, identification and development of a medical cadre, and final integration of national assets into a long range health care development system.

The aforementioned programs will effectively integrate several aspects of United States national strategy and may prevent escalation of a volatile situation into a violent application of national power. Development of a preventive medicine program that effectively includes identification of area health problems can improve the economic situation of an area by preventing economic drain due to medical expenditures. An effective training program provides a needed cadre base by which to accomplish the provision of direct health care. One warning in this area is the prevention of "brain drain".³ The training program must include a provision that prohibits trained personnel

from leaving the area and emigrating to another area, such as the United States. Failure to prevent this drain of trained personnel could have a negative effect on the creation of stability, which is the opposite effect that you want to accomplish.

The final portion of this program is the development of a long range comprehensive health care system. Utilizing the successes of the first two parts of the program, the development of a total system allows the integration of military and governmental programs to achieve the national purpose. To do this, the initial concentration of resources must be in rural areas. By doing this, problems identified during the initial phase (identification of health problems) can begin to be treated, thus enhancing the sociopsychological element of national power. Additionally, utilizing integrated U.S. and local personnel, you reinforce the fact the program is operating under the auspices of the local government, thus enhancing the political element of national power. Often urban areas tend to support the national government, while rural areas do not. A show of interest and care in these rural areas could help the government gain support; stabilization is an obvious result. Finally, this rural phase of the program has a threefold benefit for the United States forces in the area: as is the case in Central America, the use of military medical forces provides an expansion base should conflict be initiated requiring combat forces; next, it allows training of a cadre of area medical specialists who rapidly become familiar with diseases and other area-unique medical problems that can be deleterious to United

States forces introduced into the area;⁴ and, most important, provides a strong moral argument that creates positive effects on world opinion and world law, as opposed to the negative impact of the use of combat force.

The commitment required to accomplish this must be long range. A total integrated system needs to be established, not one or two high-visibility aid projects. The military, trained in this area, would be an integral part in the development, execution and evaluation of the program. Successfully coordinating the funding with the Agency for International Development, which, under the Foreign Assistance Act of 1961 would be responsible, would ensure bureaucratic cooperation.⁵

The use of medical or other nonviolent assets for strategy attainment is not a new idea nor a well kept secret. Soviet and Cuban advisors in Nicaragua include more medical and educational forces than combat personnel.⁶

The beginning of this chapter alluded to "medical power". This discussion attempted to demonstrate that the proper execution of national strategy can include nonviolent military methods. Medical power offers the opportunity to integrate all four elements of power, provides a reasonable alternative to initial use of combat forces and provides an expansion base for support should additional forces be introduced into the area. National objectives can be attained utilizing resource effective, politically popular methods. The achievable end- peace-can be attained using nonviolent military means.

ENDNOTES

1. Arthur F. Lykke, Jr., ed., Military Strategy: Theory and Application, p. 29.

2. Michael E. Howard, Clauswitz, p. 35.

3. James W. Hendley, Health Services as an Instrument of United States Foreign Policy Toward the Lesser Developed Nations, p. 404.

4. John F. Taylor, COL. and Jerry L. Fields, LTC., Health Care as an Instrument of Foreign Power, p. 49.

5. Ibid., p. 11.

6. Ibid., p. 6.

CHAPTER III

DOCTRINAL GUIDANCE

The previous chapter identified the multiphasic possibilities in the employment of medical assets to assist in attaining national objectives. If early employment of medical assets and other nonviolent military and political means were unsuccessful in preventing escalation of the situation to violent military means, further employment of portions of a campaign plan must be effected. This campaign plan must "...provide the commander's vision and intent through broad concepts for operations and sustainment...to achieve the strategic military objectives assigned by national or theater authorities".¹ One major element of this sustainment- health service support- must be included.

The importance of medical support has again been reinforced at the strategic level by former Secretary of Defense Carlucci in his last report to Congress. A significant portion of the report is devoted to medical readiness . Failure to apply such strategic guidance to the campaign planning sequence can have deleterious effects on your forces and the accomplishment of the national objectives in the campaign. The 1943 Japanese campaign in the

Southern Resource Area suffered because of severe Allied interdiction and the large Japanese troop losses from disease and other insufficient medical planning; Japan overlooked the importance of medical logistics as part of a military strategy.²

The relationship, however, of medical issues to operational planning still may be unclear in some planners minds and actions. The strategic guidance a campaign plan seeks to accomplish will often include territory, type of weapons and selected force allocations. All these areas can affect medical force structure. The campaign should not be long, unless time is being used gain advantages in other areas; protracted campaigns do not serve strategic purposes and can significantly increase the chances of defeat.³ As will be shown in chapter IV, employment of certain medical assets, especially corps level and higher assets that have little mobility, can decrease the options available, decrease flexibility and thus possibly protract the conflict.

Another reason for the lack of connection between medical issues and campaign planning is the similar lack of connection between doctrinal publications. For example, an Army War College publication states theater strategy should look ahead and provide a reason for programming selected resources.⁴ Relegating sustainment to a pure programming effort without a tie in to the proverbial "why" can be, at best, confusing. Definitive studies of health services and medical logistical support since World War II concentrate on the programing aspect as opposed to the

understanding of the why of the effort. For example, Neel's definitive study of the medical services provided during the United States' involvement in Viet Nam concentrates on the planning effort based on anticipated troop lists; no mention is made of campaign objectives nor integration of support plans.⁵ The capstone medical doctrinal manual for medical support of a Theater of War, Army Field Manual 8-10, does not even mention a campaign plan nor the achievement of operational and strategic objectives. Granted, the age of the manual (1976) might be the reason, since campaign planning and the associated language were not the focus of attention in the 1970's, but the discussion of asset employment without any mention of operational objective linkage does not lead to total understanding of the campaign process. A more recent continuation of the trend was demonstrated in the report published by the task force commissioned by the Secretary of Defense to study sustainability; no relationship between strategy and sustainability is identified.⁶

Clarence Smith's history of World War II is the one exception that relates health service support issues to not only operation art, but also to national strategic objectives. The winter of 1944 showed a situation where there were more American patients than fixed beds available in the European Theater. One of the primary reasons for this dangerous situation was a failure to understand the impact sustainment can have on a multitheater campaign. The chief surgeon of Europe failed to follow evacuation policies established by the War Department. Specifically, he did not believe in utilizing normal troop transports for the

evacuation of patients. There was a shortage of hospital ships and the troop transports were all that were available to evacuate patients to the zone of the interior. This buildup of patients had a three-fold effect: first, theater beds were not being made available, causing a shortage; second, if the patients were not evacuated, future transport assets would be misutilized; finally, full utilization of available hospitalization assets in the Zone of Interior, the United States, was not accomplished. The war in Germany was nearing an end; assets would need to be shifted to the Pacific Theater. Timely intervention by the Chief of Staff of the Army prevented the massive buildup of patients in the European Theater, and insured transportation asset availability in the next campaign. Thus, a concrete example of the reason to link campaign (and war) strategy and sustainment planning was demonstrated.⁷

One of the reasons for the scarcity of doctrinal critiques may also be the nonavailability of historical sources to analyze. The 1945 "Downfall" strategic plan of the United States Army Forces in the Pacific was designed to force the unconditional surrender of Japan by seizing vital objectives in the Japanese Archipelago. Although this plan may be considered more conceptual than operational, it still serves to illustrate planning shortfalls. Medical directives to support this extensive effort consisted of two short paragraphs describing "boilerplate" doctrinal guidance available in any standard military manual on health service support.⁸ The significance of this brevity can

be two-fold; either the established procedures for medical support were firmly established and universally understood, or planners gave little credence to the potential positive contribution of health service support. Being an optimist, and not wanting to argue with success, I will favor the former premise; not having the supporting medical annex to review (if one was published; the events in Hiroshima and Nagasaki prevented execution of this plan) does not allow me any other option.

The "Downfall" plan has a significant strong point that I must emphasize- the strategic objectives were clear, concise and left no room for misunderstanding:

To force the unconditional surrender of Japan by: (1) Lowering Japanese ability and will to resist by establishing sea and air blockades, conducting intensive air bombardments and destroying Japanese air and naval strength. (2) Invading and seizing objectives in the industrial heart of Japan.⁹

Even the current concentration on joint service efforts has not generated the needed written guidance. A campaign plan may not be an integral part of the joint planning process, but it must synchronize land, sea and air efforts against the enemy center of gravity.¹⁰ This exemplification of jointness is credible; referring, however, for guidance in Armed Forces Staff College Publication 1, the Joint Officer's Staff Guide, the only mention of the medical contribution is the discussion of the planning module, giving rates, asset availability and requirements planning.¹¹ While this information is useful in

the execution phase, reference to the strategic implications of this support is needed to allow the continued successful prosecution of the campaign.

ENDNOTES

1. William M. Mendel and Floyd T. Banks, Jr., Campaign Planning, p. 7.

2. D. Clayton James, "American and Japanese Strategies in the Pacific War," in Makers of Modern Strategy: From Machiavelli to the Nuclear Age, ed. by Peter Paret, p. 718.

3. U.S. Department of the Army, Field Manual 100-5, p. 29.

4. William W. Mendel, "Theater Strategy and the Theater Campaign Plan: Both Are Essential," Parameters, December 1988 pp. 44,46.

5. Spurgeon Neel, Medical Support of the U.S. Army in Vietnam, 1965-1970, p. 3.

6. Institute for National Strategic Studies, National Defense University. Preliminary Report of the Sustainability Task Force, p. 1.

7. Clarence McKittrick Smith, The United States Army in World War II, The Technical Services, The Medical Department: Hospitalization and Evacuation, Zone of the Interior, p. 236.

8. General Headquarters, U.S. Forces in the Pacific, Downfall: Strategic Plan for the Operation in the Japanese Archipelago, p. 12.

9. Ibid., p. 1.

10. William W. Mendel and Floyd T. Banks, "Campaign Planning: Getting it Straight," Parameters, September 1988, p. 46.

11. U.S. Department of Defense, Armed Forces Staff College Publication 1, p. 181.

CHAPTER IV

MEDICAL PLANNING IN SUPPORT OF THE THEATER

"Employment of medical assets in a timely manner". Nice phrase, sounds good, but what does it mean? More important, what do medical assets have to do with strategic or operational planning? I will discuss how key decisions on medical force structure, deployment and joint planning can affect the outcome of a campaign. I will also concentrate on one major problem-patient evacuation.

War- the employment of military power to attain political goals- should be at the end of a continuum that begins with the establishment of a goal at the political level. The continuum includes the development of strategy for goal attainment, conversion of the strategy to operational and tactical considerations and, finally, ending with a trigger puller accomplishing his mission. Medical support must also be a continuum- a reverse of the previous continuum because it begins at the forward battle area and carries a patient successfully through to the CONUS base.¹ If that continuum is successful, the health service support system can increase the return-to-duty rate, thus conserving the human component of a commander's weapons system.² If the continuum is unsuccessful, the primary source

of trained, war hardened replacements does not function adequately. This brings you to the first problem as a theater campaign planner-how much medical support is needed, or can be supported, in your theater campaign plan?

In developing a plan for theater medical support, the simple thing to remember is the more medical assets you have, especially staffed hospital beds, the more medical return-to-duty personnel can be provided. As with the employment of all assets, there is a trade-off; deployment of a large number of hospital beds consumes valuable lift assets during the initial stages of a theater buildup. The decision for a large medical force can also be used to send a strategic signal to your opponent; it shows you plan to stay in an area for a longer period of time. This determination is demonstrated by your committing a valuable asset that requires considerable manpower, logistical support and time to establish and sustain.

The alternatives to large amounts of in-theater medical support include host nation support, extensive medical evacuation at the tactical and strategic levels or the use of combined assets if available. As with the first option, these choices also demonstrate strategic goals to your enemy. Limited employment of medical support, as with any element of sustainment, usually shows the desire to employ forces for a short duration. Knowing the intense regard the United States has for human life, limited medical force employment can also demonstrate we have identified sufficient support in the area to provide the needed hospitalization. This support can be from the host nation or friendly

nations in the area. The natural strategic implication is the will of the area governments to support what the United States is trying to accomplish in the area.

The limited employment of medical assets has a significant effect on the requirement for a timely evacuation system. Utilizing the European Command (EUCOM) as an example, I will show why this may not be a viable alternative.

As there are principles of war, there are principles of sustainment. For the purpose of the paper, four of the commonly agreed upon principles will be highlighted: simplicity, unity of command, responsiveness and timeliness.³ A quick review of the Army medical evacuation system is needed before continuing. The basic point in medical evacuation is based on the principle of higher headquarters going forward to evacuate a patient from lower headquarters. From the battle area to the corps area, this system works, albeit limited to the availability of evacuation assets. The problem begins at the corps/theater interface. As the Army describes war as having three divisions-strategic, operational and tactical- the medical department has two levels of evacuation- tactical and strategic. Tactical evacuation is the movement of a patient from corps to theater; strategic evacuation is the movement of a patient from the theater to CONUS. It is at the tactical evacuation level that joint medical operations normally begin and also have the greatest risk of failure.

Tactical evacuation is initially controlled by a joint medical regulating office(JMRO) and relies primarily on Air Force tactical airlift assets. The system, which I am about to

explain, was described by a former commander of mine, currently a three star general at DOD, as a "system designed for failure." Once a corps evacuation policy is established, using seven days as an example, any patient that would require more than seven days to recover must be evacuated out of the corps medical facility. Before the evacuation can occur, the patient must have a place to go; at this point JMRO enters the process. JMRO is contacted by the corps to request a theater-level bed for the patient. JMRO surveys available beds in the theater and finds a receiving bed for the patient. JMRO then notifies the requesting hospital of the receiving facility and the airfield closest to the receiving facility. At this point, the system tends to break down. The army does not have adequate assets to move the patients from corps to theater. Several initiatives have begun to alleviate the problem, such as development of host nation bus ambulance units staffed with reserves driving civilian buses, and the possible purchase of ambulance trains, similar to the one the army sold to England in the late 1960's to get rid of the units. While these efforts are commendable, they are not operational and a parallel system could not be utilized in a developing theater, since they require long lead times to effect.

Returning to the evacuation system, somehow the Air Force C-130 fleet must be utilized. In every corps, there is an Aeromedical Evacuation Liaison Team (AELT) that provides an interface with the Aeromedical Evacuation Control Center (AECC). Once JMRO tells the corps hospital where to send the patient, the hospital requests transportation from the AELT. The AELT goes to

the AECC for help. The AECC does not own any aircraft; it functions as a liaison to the Airlift Control Center (ALCC). This center schedules all airlift assets and should know asset availability. C-130's are general purpose aircraft and are not dedicated for a specific category of mission, such as medical evacuation. Medical evacuation is accomplished using backhaul from aircraft that have delivered items to the corps area and are returning to bases in the rear. The ALCC must find an aircraft going to a corps airfield near the requesting hospital, ensure the aircraft can be utilized in a backhaul mode, schedule it to go to an airfield near the receiving hospital, and contact the AECC, which passes the information to the AELT. The AELT notifies the receiving hospital where and when it must take the patient to link up with the aircraft. In CPX play, this process takes a minimum of 36 hours; in FTX play, it is so tightly scheduled in advance that times do not indicate reality.

Earlier, I mentioned some principles of logistics. Three of the principles, namely simplicity, timeliness and responsiveness, are not demonstrated with this system. The forth- unity of command- is not in evidence, since the medical commander has no control over the accomplishment of the evacuation. The failure of this system results in increased deaths and prolonged hospitalization. The implications for the war effort are many: fewer medical return-to-duty replacements, a jammed medical system that can not be responsive to the needs of the combat commander, and a self imposed attack on one of our own Clauswitzian centers of gravity- national will. The numbers of

casualties has an adverse effect on our national will- the more casualties, the less the determination of the population to support the war, as was demonstrated during Viet Nam.

The answer or solution is not easy. The theater commander will never have enough medical force structure needed to avoid evacuation. The Air Force will never have enough assets to dedicate tactical airlift for medical use. What can be affected is the request and response system. Sustainment (read logistical) support needed for combat forces is finite and fairly well determined in advance of an operation. Variables such as intensity of combat and availability of lift assets affect not only sustainment, but also the amounts of casualties generated by an operation. For example, large expenditures of ammunition and other supplies usually correspond to more casualties. Additionally, the finite number of hospital beds at corps and theater facilities are also known. Establish a schedule in advance of a campaign. This schedule would state logistical delivery times at specific airfields. The schedule can be varied for operational security reasons, as long as all users of the system are notified. Every flight must be designated to carry backhaul- personnel, equipment, black boxes, etc. Based on decisions of the CINC's joint transportation movement board, who currently set the movement priorities, a specific percentage of every plane would be earmarked for each category of retrograde. Space not utilized by a specific category could be utilized by another category. Receiving airfields would be identified, and the result is a "sustainment shuttle." No additional assets are

needed, since all classes of supply would continue to be moved to needed areas. This process would eliminate the AELT, AECC, and ALCC loop in the evacuation process. These agencies still have a role to play in providing medical personnel, but the communication logjam would be eliminated. Tactical, or medical, emergency evacuation requests could still be passed using these agencies. JMRO would still identify the receiving hospital, but all the corps facility would do is choose the right shuttle. If enemy activity prevented use of air, nothing would be lost, since under both systems, ground alternatives are needed. Responsiveness, timeliness and simplicity are enhanced.

While the tactical air evacuation problem still exists in the European theater, several initiatives have begun to ensure attainment of the medical portion of the campaign objectives. During the period 1981 to 1984, deficiencies affecting medical support existed in the following areas; communication, utilization of codes, availability of theater-level beds, host nation approval of wartime use of selected facilities and the selection of appropriate planning factors. By the summer of 1988, European Command and U.S. Army Europe medical authorities had accomplished the following:

1. Communications. Division, corps and theater-level medical assets now possess the potential to communicate with each other utilizing military and host nation communication equipment.
2. Codes. Commonality of codes enables the passing of required interservice reports in a secure mode. Previously, common codes were not available, and what one service transmitted in code, another service from the same nation transmitted in the plain.

3. Theater beds. Several prepositioned general hospital sets (1000 bed) were moved into the theater. Additionally, turnkey general hospitals were established in two NATO countries, allowing rapid opening by troops deploying from the United States.

4. Host nation approval of facilities. The process of obtaining approval from the host nation for use of selected facilities during emergency conditions has significantly improved. A process that in some cases previously took over five years was shortened to less than six months for certain facilities.

5. Planning factors. This area still has not been resolved. Based on the scenario, battle casualties are estimated and appropriate theater medical support is programed. The viability of these figures, mandated by the Joint Chiefs of Staff, is subject to question. Two nations, planning for the exact same battle, in the same area, against the same enemy forces, have casualty figures that vary by four times as much. As long as you error on the side of caution, I see no problem. However, it is difficult to explain to wounded soldiers that their country has underestimated medical requirements by 400%!

All the aforementioned areas have significant impact on the execution of the theater campaign plan. Continued improvement in these and other areas, coupled with the understanding of the role of health service support in theater campaign strategy, can significantly assist the theater CINC in the accomplishment of his campaign objectives. It can increase the availability of his most important asset-the American soldier-and ensure success in maintaining the support of the American people.

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1. U.S. Department of the Army, TRADOC Pamphlet 525-50, p. 2.
2. U.S. Department of the Army, Field Manual 8-55, p. 5.
3. James A. Huston, Army Logistics 1775-1953, p. 655 and General Carl E. Vouno, "Sustaining Combat Power," Army Logistician, July/August 1988, p. 786.

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